HEALTH SERVICES FOR ALL: IS HEALTH INSURANCE THE ANSWER?

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ONE must assume, in view of the interests and contributions of the man we are honoring today, that the words "health insurance" must refer to governmental contributory health insurance. The term itself is, as so often pointed out, misleading. The systems which have been developed all over the world certainly do not insure health. Some have suggested "sickness insurance" as being more accurate, but even that is ambiguous. What most of them do is to insure against the costs of medical treatment and one is tempted to think that a more accurate name for our own venture into health insurance would be "Medicost," rather than "Medicare."

Essentially, health insurance is a method of spreading the costs of medical care, broadly or narrowly interpreted, over as large a proportion of the group at risk as possible. It is one device for removing all, or part, of the financial barrier to the receipt of medical care and health services. One would have thought that the case for using this device would have been so obvious that the United States would have long ago followed the example of other countries and instituted a health insurance system.[1] I still remember my astonishment when I arrived in this country in 1926, a wide-eyed student eager to learn about the social institutions of the United States, to find that apart from workmen's compensation there was no form of social insurance in effect, and that any such institution was regarded as something possibly appropriate for effete and unprogressive Europeans but certainly not needed by self-reliant and wealthy Americans. Even with the onset of the depression, which turned men's minds to consideration of ways of assuring income maintenance, it was unemployment insurance, and to a lesser degree old-age insurance—but not health insurance —that attracted professional discussion and attention.

In fact, of course, there had been earlier interest in health insurance. In 1912, National Health Insurance had been one of the major planks in Theodore Roosevelt's Progressive Party; organized social workers had made studies and proposals; several states had introduced and debated compulsory health insurance bills, and even the AMA had appeared to approve the principles embodied in some of these bills. Anne and Herman Somers have reminded us that as late as 1917 the AMA, when adopting a resolution concerning the principles that a proper health insurance system should include, stated "the time is present when the profession should study earnestly to solve the questions of medical care that will arise under various forms of social insurance. Blind opposition, indignant repudiation, bitter denunciation of these laws is worse than useless: it leads nowhere and it leaves the profession in a position of helplessness as the rising tide of social development sweeps over it."[2] One can only say "Amen!"

And "amen" in another sense it was! The war came, and when it was over the AMA, responding to the adverse reactions of state medical societies, de-

clared its formal opposition to any plan of compulsory contributory insurance operated or controlled by government. The social workers turned their attention to the acquisition of professional status, stressed clinical service and casework and spent their energies on the absorption of Freudian principles that seemed to offer a basis for a unique, identifiable professional service. Until the Depression, social policy in general was neglected by them. Nor were matters helped by the stance of organized labor, which might have been expected to lead a movement for social insurance. For it was not until 1932 that the AFL formally withdrew its opposition to social insurance, and then only on condition that the costs be carried by the employer. Interest in the subject was kept alive only through the work of a few scholars (such as Rubinow or Armstrong), and the individuals associated with both the American Association for Social Security and the American Association for Labor Legislation.

Even the farsighted Committee on the Costs of Medical Care, 1927-1932 (with which I. S. Falk was prominently associated) while it recommended, in its majority report, financing through comprehensive group payment, placed its reliance on voluntary action and refrained from recommending compulsory public health insurance. In subsequent years the spectacular growth of private (profit and nonprofit) health insurance seemed to promise that voluntary action might indeed be the answer.

The next opportunity for action came in 1934-1935 but the Committee on Economic Security did not include any proposals for health insurance in the proposed social security legislation, reportedly because it was felt by the Administration that to include so controversial a plan would have endangered the other, extremely important, old-age and unemployment-insurance provisions. I am hopeful that Dr. Falk, who was deeply involved in that part of the committee's work, will tell us more about that missed opportunity.

We are all familiar with the subsequent story: the efforts to enact federal health insurance (especially in the immediate postwar years), the gradual whittling down of the objectives—until we find ourselves, in 1965, regarding the passage of a limited health insurance measure for the aged as a great victory. To the extent that it is the *premier pas qui coute,* the 1965 legislation is of course an important milestone, the more important because of the very violence of the opposition. And yet from a broader perspective there may be less cause for rejoicing, for some of the price that was paid involved compromises that may make future progress more difficult.[3]

I have always been a great proponent of social insurance, and regard it as one of the major social inventions. It effected the transition from reliance on charity or grudging, and often degrading, public aid to a system of rights to socially assured income in the event of specific occurrences. It did so by linking the bestowal of rights to the concept of insurance, a thoroughly respectable and respected institution. So successfully was this done that today it is difficult to get students to realize that before 1935 in this country, not only was it a problem of getting the voters, as a group, to accept the fact that giving old or unemployed people the right to cash payments without undergoing a means test would not undermine the very basis of our capitalist free enterprise system, but it was also necessary to persuade the potential beneficiaries that there was nothing wrong or shameful about accepting such payments. The word "insurance" performed a very useful social function.

But social insurance has done more than this. In has proved to be a very effective method of raising money to finance welfare programs. People seem much more willing to pay taxes if they

feel that they are going to benefit personally and directly from the expenditures. There is another side to this coin, of course, for we must never forget that it was the social insurance tax systems with their provision for employer withholding and their acceptability to workers which opened the eyes of Treasuries to the fact that it was indeed possible to tax low-income receivers. Politicians have not been blind to this fiscal advantage of social insurance. In 1925, contributory old-age pensions in England were enacted by a Conservative government that was under great pressure to liberalize the noncontributory income-tested old-age pension system. Similarly it is not, I think, by accident that recently the governor of New York, faced with mounting costs of Medicaid, has become a most active proponent of compulsory health insurance.

In somewhat broader terms, contributory insurance also appears to provide some check on irresponsible liberalizations. The linkage of benefits and taxes has undoubtedly served up to now as a useful control in a world where competition for the taxpayers dollar is intense. Finally, as its scope has widened (and coverage in terms of people had to be fairly broad even initially, in the interests of spreading the risk) social insurance has served as a socially cohesive force. It is not a program solely for "the poor." From the first a cross section of wage earners has been covered, thereby including the upper working-class groups, and increasingly the middle classes have also been included. Involvement of the direct interest of the middle classes has prevented social insurance from deteriorating into a program for the poor, for whom, alas, it often seems to be felt that anything is good enough. In a world that is increasingly subject to divisive forces, social insurance has stressed solidarity and mutuality of interest.

So long as it was confined to dealing with loss or interruption of income, and to the making of cash payments, this instrument performed remarkably well. It has been essentially a mechanism for collecting funds and paying them out in specified contingencies. There have of course been problems and troublesome policy issues but they have proved manageable. There have been administrative problems in determining the occurrence of the risk insured against: what is involuntary unemployment?, when has a man retired?, how to assess the degree of disability that is held to prevent a man from working?, and the like. And there have been policy issues: who should be covered?, what level of benefits should be payable?, how should the costs be allocated among the covered population, their employers, and the general taxpayer?

These problems have been difficult enough but they are simple in comparison to those faced when social insurance is used to deal with the financial barriers to the receipt of services. Services have to be rendered by professionals whose responsible cooperation with the program is essential. When cash payments are made, it has proved possible to hire mainly non-professional staffs and use machines to check eligibility and calculate payments, even when the benefit formulae and the rules governing eligibility are extremely complicated. The criteria and formulae are highly objective, call for the exercise of minimal discretion, and their application rests in the hands of the public administrator. Where payment for services is the objective, organized professionals must first be induced to render these services to the insured. This is a matter partly of determining rates of remuneration acceptable to both the profession and the wider community, and partly of determining other conditions of employment to which professionals attach importance. The extent to which services were in fact rendered is attested to by

the professionals or purveyors of service rather than by the administrator who, in effect, is underwriting all or part of a bill whose size is out of his direct control, and who depends on the professionals' competence and integrity.

Again, when making cash payments in the event of interruption of income, a dollar is a dollar. At any given time every dollar received by a beneficiary buys as much as that received by any other. Even changes over time in the value of the dollar have not proved impossible to adjust to; with services, however, the problem of variable quality arises. One then has to face the question whether the government, as operator of the system, has any responsibility for ensuring that the services received by its insured, for which it is paying, are indeed of minimally acceptable quality. In some cases the services may not be available at all and the system may be charged with deception for collecting contributions to pay for services that do not exist.

There is yet a third complication. In social insurance systems dealing with income maintenance, the question of how much of the taxpayer's income is to be devoted to this end (income transfers) can be openly debated and controlled by legislative decisions on eligibility rules and benefit formulae The global costs of any given combination of these can be estimated with a high degree of reliability so that rational choices are possible and, once made, the administrator can control them. When it is a matter of paying for services, cost (i.e., the taxpayer's bill) is affected not only by the decisions of individual practitioners and purveyors of care as to how much service is to be rendered but also by the prices charged by professionals and institutional suppliers, and by the efficiency or inefficiency of the organizational arrangements for the delivery of services.

There is one final difference in the application of social insurance to the problem of income maintenance and its application to the problem of health services. All social insurance systems contain eligibility criteria. Only those persons who have been "covered" for some specified period, or have paid some specified amount of taxes, or are related in some defined way to the insured person are eligible for benefits. This limitation of access to the program may make sense in a cash payment system, although we often carry the exclusions too far. As an example, if the system exists to replace income from work, then one needs some proof that the claimant was indeed normally working and the eligibility rules aim to test this and to eliminate the voluntarily unemployed. But once it is realized that the function of eligibility rules is to keep people out (i.e., to exclude), one may ask whether this concept is appropriate to a health service system where surely one wishes to exclude nobody who is in need of health services.

It is perhaps not surprising that most countries, notably including our own, have first conceived of the problem in the health services as being one of removing the financial barrier. Even so, it has proved impossible to escape the problem of ensuring professional cooperation; in most countries the history of health insurance is replete with disputes between the authorities and the medical professions as to rates and methods of pay, and conditions of employment.[4]

So far, we have not been very effective in using health insurance to remove the financial barrier. In the first place the coverage, in terms of population, is very restricted. The history of the postwar movement for health insurance is one of gradual retreat from the goal of almost universal coverage, as embodied in the early Wagner-Murray-Dingell Bills, to coverage of the narrower group of the aged. Given the strength of the

opposition, the 1951 decision to concentrate on the aged was probably inevitable. Their plight, in terms of need for health services and limited income with which to pay for them, could be demonstrated. The inability of private insurance to deal with the problem was becoming daily more evident, even to the insurance companies themselves. An effectively operating instrument, namely OASDI, was available, and the aged were numerous and had votes.

From a longer range point of view, of course, this concentration on the aged makes no sense. If the nation is unwilling to open the doors to needed health services for everyone, a different priority would seem obvious. A powerful case could be made for beginning at the other end of the life span and removing the barriers to health services for children. The national interest in having a healthy and productive labor force would alone argue for this, quite apart from other considerations. Perhaps even now we may hope that some ingenious mind will invent some way to reverse the concept of paid-up insurance as now applied to the aged and to provide postpaid insurance so that children can have health insurance protection *before* they enter what is now an almost universal coverage system. Assuming certain changes in our present health insurance system, which I shall later suggest, this would surely be a better way of ensuring at least minimal health care for children rather than, as now, leaving them to the uncertain outcome of Medicaid developments.

I also suggest that we should not be too surprised at the recent reaction against Medicaid on the part of both Congress and the states. In my judgment, Title 19 attempted to achieve too much, too fast. To my knowledge, no other grant-in-aid program has ever been so completely open-ended or left the federal taxpayer so strongly committed to pay a bill the size of which he could in no way control. No other federal grant-in-aid program has ever contained so many standards and requirements for state programs; all these standards and requirements aimed at wider coverage and increased service, and carried the penalty of loss of existing federal grants if the states did not conform by specified dates. In any case, the objective of providing needed health services for all children through Medicaid will always be thwarted by the fact that everything depends on state action and whatever service is provided will reflect differences in states' resources and interests. If we are serious about providing for children with at least minimal adequacy, we shall have to look to federal action.

The inclusion of children and aged in federal health insurance would leave the productive age groups unprovided for. It is difficult to forecast the extent to which they will be able to meet the problem of health costs through private insurance. My own guess is that we shall increasingly find, as medical care costs rise, that private insurance will have a harder and harder selling job, and will find it difficult to cover an acceptable percentage of the ever-increasing medical bill. If this is so, we must expect pressure to extend federal health insurance to other adult groups. It seems obvious that Medicare will soon be extended to additional social security beneficiaries. The same arguments that were compelling for the age-65-and-over group apply equally to the disabled and to early retirees. Nor will it be easy in the years ahead to resist the claims of survivor beneficiaries whose incomes are, for the most part, limited.

I said earlier that we have not been very effective in using social insurance to remove the financial barrier to health care, in part because we limit coverage. However, in the immediate future the task of making health insurance more adequate (in the sense of doing the job it was devised to do more effectively)

will be more important than extending coverage to more people. As a method of removing the financial barrier to access to needed health services, Medicare has two gross defects.

First, it still leaves the insured person with a sizable medical bill over and above his annual premium, because of the provisions for deductibles and co-insurance, and because of the leeway in Title 18B which permits doctors to charge what they think the traffic will bear over and above the reimbursable "reasonable and customary" charges. So far as deductibles and co-insurance are concerned, justification is apparently based on the assumption that people have an inordinate appetite for medical care and hospitalization, and this appetite must be checked. It is evidently also assumed that one cannot trust the professionals whose decisions govern whether a patient shall go to hospital or undergo specific tests or procedures. These assumptions need to be tested by research.

Admittedly there is a real problem of ensuring responsible use of a service that, apart from the premium, would be free. But an intelligent society would surely seek controls that do not have the undesirable consequences of forcing the patient to bear a sizable share of the bill over and above what he pays by way of a premium. Increasing efforts must be made to enlist more professional cooperation and self-policing. The experiences of nongovernmental prepaid comprehensive health plans with such controls must be more carefully studied, especially because these lend themselves to experimentation more readily than does a national program.

The limited financial protection of the patient, due to the physician's freedom to collect from him more than he will be reimbursed for, will be especially difficult to change. It was presumably part of the price paid for physicians' participation in the program. Perhaps we have to await a new generation of doctors whose professional training, we may hope, will include a far broader and more socially oriented concept of professional ethics.

The second shortcoming of contemporary health insurance is its selectivity about the reimbursable types of treatment and the places where treatment is received. This unfortunate item-by-item approach to the payment of medical costs is further complicated by the existence of two separate and confusing reimbursement systems, Parts A and B. From the financial point of view, this policy of reimbursing for some items only, again leaves some patients with sizable bills and limits the extent to which health insurance removes the financial barrier.

The major thrust of reform should be directed to removal of this selective reimbursement system for even more compelling reasons than the financial one. The present reimbursement system interposes an unnecessary barrier to the planning of appropriate courses of treatment, distorts professional advice by considerations of finance, and influences the extent to which patients can or will act on the advice given. Above all, this item-by-item method of meeting the costs of medical care, coupled with the exclusion of some items, fosters fragmentation of service, which is the outstanding weakness of our present system for the delivery of health services.

Thus I would urge that the first priority for effective utilization of health insurance is insistence on comprehensiveness of service coverage. This is even more crucial than removal of deductibles and co-insurance, and it is more important than extending coverage to additional population groups, even though the latter is desirable and politically feasible.

I said earlier that the dimensions of the problem of assuring health services for all are broader than the mere re-

moval of the financial barrier. Availability of facilities, supporting services and personnel, assurance of high quality of service, and economy in the use of funds and resources—all call for urgent attention. To what extent may we expect the health insurance system as such to grapple with them? Certainly not all health insurance systems have accepted responsibility in these areas. Between 1911 and 1948 the British Health Insurance system limited itself essentially to paying bills. Availability, quality, and use of resources were none of its concern. Health insurance systems in other countries either have been slow to act in these difficult areas or have done so only with reluctance. Nor is it surprising that initially the question of availability and quality of care should have been relatively neglected by the health insurance authorities. For in the 1880's when Germany began to develop its system, and the early 1900's when Britain and other countries were developing their systems, the scientific revolution in medicine had scarcely begun. What passed for acceptable medicine in those days was less highly skilled and less scientific than now. Probably there was also more uniformity in the more limited professional service then available. Probably people in general were less aware of the potentials of good health services and of the difference between good and poor quality service. We live today in a scientific and technological era, and people's sights have been raised. Today, people will not be satisfied with the mere removal of the financial barrier, and we can no longer neglect the organizational and related problems that have been brought about by the scientific and technological revolutions.

Some health insurance authorities have, however, made efforts to deal with problems of supply, availability, and quality by building and operating their own hospitals, clinics, convalescent homes, and other facilities in which their own staffs provide group care. I do not see us following this pattern, at least not until the population coverage of health insurance is much wider than it now is. Parallel delivery systems, one for the limited group of the aged that is insured and another for the noninsured, would perpetuate and strengthen our already undesirable two-class health-service system. Such a policy would be met by insistence by the medical profession on free choice of doctor, a demand which appears to have considerable support from the population at large. We here may recognize that realistically—even when the financial barrier is removed—free choice of doctor is largely an illusion because choice is restricted to the selection of the primary physician, and free choice of institution is limited by the availability of beds and the admission policies of individual hospitals. However, the idea of free choice has broad popular appeal. Our hope is that the health insurance system will prove flexible enough to give full support to groups providing comprehensive high quality care and that in time the superiority of this method will become evident and win out in competition. But here again there will be need for both careful evaluative studies and wide dissemination of the results.

Other countries such as Sweden have responded to the problem of supply and availability by direct provision by government, rather than by the health insurance system, of certain types of institutions such as hospitals. These are open to all on either a free or a nominal charge basis and when charges are made, the health insurance authorities purchase service on behalf of their members. I suspect that this will be the more probable trend in the United States. The health insurance system will remain largely a financing mechanism but government will be heavily involved in the construction of facilities that are either

publicly operated (directly or through public corporations) or privately operated under increasingly close public supervision. Government will also play a large role in assuring an adequate supply of needed personnel through subsidizing education and training.

It already seems evident that the health insurance administrators in the United States cannot escape some degree of involvement in our second major area of concern, quality of care. A major step in this direction has been taken in the formal Conditions of Participation laid down for certain types of institutions and providers of technical services. Quality control will, however, be easier to achieve for institutional care than for practitioner services. In both cases, two needs are apparent. To the extent that the instrument used is accreditation (or licensing) and consultation, we must develop stronger and better staffed state (and even local) health departments. There is also a need for much more research into measures of, and methods of control over, quality.

On the the third major problem, economical use of health resources, we may indeed expect major leadership to come from the health insurance authorities. Inefficient or uneconomic resource use by a health insurance system shows up immediately in increased costs that at once become visible and onerous through increased contributions or taxes. We may therefore expect that the administrators of Medicare will increasingly chafe under the restrictions imposed by the preamble to Title 18, whereby there is a disclaimer of any effort by government to interfere in the methods by which health services are delivered and administered. I am also sure that the Congress will look with increasing favor on investigations into the extent to which the methods of rendering services, and the organization and administration of medical institutions, involve unnecessary costs. There is already an awareness of the extent to which reimbursement formulae can affect costs. The amendments of 1967 authorize the Secretary of HEW to experiment with various methods of reimbursement to physicians and organizations "that would provide incentives for limiting costs of the programs while maintaining quality care." Once again a vast new field for demonstration and research has opened up. The Medicare administrators will also possess a rich store of data which will facilitate sophisticated statistical comparisons of the performance of both institutions and practitioners. As the arrangements for determining reasonable costs and charges are renegotiated, the purveyors of health services will have to be prepared to answer some awkward questions.

At the same time there is a danger in sole reliance on the health insurance authorities to press for more efficient methods of delivery, for their main concern will be financial. It is not always the case that the method which saves money is the one that renders service in the most desirable way. Many of the changes that one might envisage, such as a central data bank or a centralized community-operated ambulance or laboratory service, would meet the demands of both economy and better service. But from such reading as I have done, it does not seem indisputably clear that group practice, although it renders better service, is necessarily cheaper than solo practice. The need therefore is for vigilance, a vigilance that must come from two sources. On the one hand we need more knowledge from nonofficial sources about what is happening; here the responsibility is clearly on the universities, medical schools, and research centers. On the other hand, we need to make more provision for representation of the consumers in the administrative structure of our health insurance sys-

tem. Up to now we have been extraordinarily fortunate in the caliber and sense of public interest of the federal administrators, but they are in a difficult position and are subject to heavy pressure from the organized purveyors of health services. The administrators need an organized constituency on the other side, if only as a countervailing force. It is neither fair nor reasonable to expect them to carry the entire responsibility for protecting the interests of the consumers of health services. High on my agenda for making health insurance a more effective instrument in this country is provision for more effective user representation and influence.

Like Dr. Falk,[5] I do not see us moving rapidly toward a national health service. I still believe a free national health service to be the most effective instrument yet devised for assuring universal access to the full range of comprehensive health services; even while saying this, I recognize that national services also have some unsolved problems. However, the very size and diversity of this country suggest that such a system would be difficult for us to organize and administer. At the same time we must not forget that we do in fact have a national health service—for veterans. Perhaps we could start by developing a national health service for children.

It took Great Britain over 30 years of experience with a much more extensive health insurance system than ours to get to the point of switching to a free health service; even then the change might not have come had not the war and the blitz thrown the inefficiencies and inadequacies of the existing system into relief.[6] The rising costs of health care may propel us faster than I now anticipate into a radical reorganization of our health delivery systems. However, unlike the British, we are affluent and can afford a lot of waste. Organized medicine in this country is more resistant to change, but even here there are some faint signs of recognition of the changed world.

Much depends too, on what happens under Medicaid. The current adverse reactions should not blind us to the potential of this program. Because it is a state- (and even a locally-) influenced program it will lend itself to experimentation. It will be of the utmost importance that these experiments be recorded and evaluated. We may indeed find that here and there Medicaid programs are developing which offer comprehensive care under nonoffensive conditions that may compare very favorably with what the health insurance system has been able to deliver. The important thing will be to make effective use of the much vaunted experimentation potential offered by our numerous states and political subdivisions—"effective use" means capturing and recording the results and disseminating widely the knowledge thus gained.

As he looks back on his long and richly productive professional career, Isidore Falk must have many reasons for satisfaction. Health insurance, for which he fought so long and so valiantly, is no longer a dirty word but an established institution. I have no doubt that in a few years young students will be describing it as "the American way" of handling a problem, as they now do with OASI! Both the changing public attitude about what is expected from a health system and the vast scientific and technological changes that have affected the health services have created new problems that are more complicated than can be dealt with by a health insurance system alone. Today we have to ask what the role of health insurance is in a complex of institutions and arrangements for the provision of health services to all. Even now we can foresee a considerably larger role for health insurance than it now plays.

Perhaps even more than in the enact-

ment of a health insurance system, Falk must feel a deep satisfaction in the increasing attention paid by scholars (medical and nonmedical experts alike) to research in the health services field. Once almost a lone wolf, at any rate a member of a tiny pack, he is today one of the outstanding leaders of a sizable and ever-growing group of men and women whose work—and this is the important point—is directed toward the solution of the health service problems of the real world. When one asks in which direction we should move, one finds the first essential is to know more about what is happening and about what works and what does not.

Despite disturbing signs of growing irrationality in the world I still believe, as does Myrdal,[7] that knowledge is a powerful force for bringing about change and reform. I believe this is Dr. Falk's credo, too. It is because he has asked questions of relevance to the functioning of our health services and because he has helped to find some of the answers, either directly or through those he has influenced, that we honor him today—a scholar whose work has affected public policy.

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COMMENTARY

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WHAT a spot Dr. Burns has put me on with that brilliant paper! Almost any discussion of it is redundant. In a sense, my spot is made still more uncomfortable by being called upon to comment on her paper before such an outstanding audience as this, for it includes most of the people who have taught me whatever I know about social insurance and medical care. To single out the individuals here to whom I am indebted would almost be to call the roll of attendance at this symposium because so many of you, at one time or another in the past 30 years, have been my colleagues, teachers, and mentors.

The gathering of such a distinguished